

# The Impact of Family on Obsessive Compulsive Disorder in Children and Adolescents: Development, Maintenance, and Family Psychological Treatment

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## Abstract

It is widely recognized that some parental characteristics can influence obsessive compulsive disorders in children and adolescents. Family involvement and parental style characterized by high expressed emotion, over-protection, over-control are associated with the development of obsessive compulsive disorders in children. As a consequence, family involvement in the treatment of youth with obsessive compulsive disorders has been widely suggested. Although various forms of family therapy are used, cognitive behavioural treatment is widely recognized as the first-line treatment of paediatric obsessive compulsive disorders. Despite several studies reveal efficacy of family therapy, it has been underlined that more than an half of children remain symptomatic post-treatment. In order to improve treatments for children with obsessive compulsive disorders, research has identified personal and familiar predictors of response to treatment. The clinical implications of these studies are discussed.

## Keywords

*Obsessive Compulsive Disorder; Childhood; Adolescence; Family; Psychological Treatment*

## Introduction

Obsessive-compulsive disorder (OCD) is an anxiety disorder that involves (a) intrusive, unwanted thoughts, ideas, or images that evoke anxiety (obsessions), and (b) deliberate behavioural or mental rituals, that serve to neutralise anxiety (compulsions) [1]. OCD affects as many as 2–3% of children [2, 3] with significant functional impairment in a number of critical domains. The obsessions and compulsions that characterise OCD interfere with social, academic, and family environments [4-5] and have negative consequences on quality of life [6].

Common obsessions in children have themes of

contamination, aggression (harm or death), symmetry, and exactness, while in adolescence, religious and sexual obsessions also become common [7]. Common compulsive behaviours reported in young people include hand washing/cleaning, counting, praying, and checking [8].

The literature review and discussion in this article focuses on the role that parents and family members have on OCD in childhood and adolescence. Family-based treatments for young people with OCD will be also reviewed and their efficacy will be discussed.

## Family Factors Associated With Childhood Ocd

### *Family involvement*

Several authors place great importance on the role of the family environment in the development and maintenance of OCD [9]. This emphasis is logical because the vast majority of children and adolescents spend a significant portion of their lives in the presence of families. In this context, it has been suggested that family members of youth with OCD are often involved in the young person's rituals [10–12]. The person's obsessive doubts, indecisiveness, constant search for reassurance, and avoidance behaviours can lead to extreme dependence on family members, who usually have to assume many of the person's activities, duties, and responsibilities [13]. Family participation in the child's obsessive-compulsive symptoms is referred to as "family involvement" or "family accommodation" [10]. Family participation can operate both directly (e.g., participation in rituals; interference with or intrusion in rituals) and indirectly (e.g., modification of the family's lifestyle around the symptoms). Some

authors have attempted to describe familiar responses to obsessive-compulsive symptoms along a continuum ranging from accommodating to antagonizing [14]. An accommodating response refers to that of those families whose members are consistently involved in, and supportive of, their child's rituals [15]. The goal of such involvement is often to help the person with OCD to reduce distress [16]. An antagonistic response instead refers to that of families who are critical and hostile towards the child's symptoms and who consistently refuse to encourage or be involved in the ritualistic behaviour. Attempting to stop the child from performing his or her ritual and forced traumatic exposure to the feared stimulus are examples of antagonistic family involvement [14]. Of course there are also situations where one parent takes the antagonizing stance and the other is accommodating of the symptoms. Even if this is a rather simplistic categorization of familial responses, one point is clear: regardless of whether families reject or accommodate the symptoms, they are often inextricably involved in the disorder. Moreover, both accommodating and antagonizing family responses tend to perpetuate and reinforce OCD symptoms, increasing the frequency and/or severity of the rituals [16-17].

### *Parenting style*

It is widely recognized that some characteristics of the family environment are associated with the development of OCD in children. One family factor that has been associated with OCD is expressed emotion [18-21]. Expressed emotion refers to a family environment characterised by hostility, criticism, or emotional over-involvement [22]. It has been found that high expressed emotion is characteristic of families with an OCD child in comparison to families with a typically-functioning child [20]. Moreover, high expressed emotion is also associated with child OCD symptom severity [21] and greater family accommodation. Moreover, parental attitudes characterized by over-protection, over-control [23], low confidence in the child's ability, low reward of independence [18], parental blame [24], low problem-solving skills, and high parental catastrophising behaviour [18-19] are associated with OCD in children. On the other hand, low affection [23] and low support [25] have been found in parents of youth with OCD. These parental attitudes may create avoidance, caution, and fearfulness in children and

thus predispose them to developing obsessive-compulsive symptoms [26]. Moreover, factors such as high parental anxiety [27] and perceived lack of control over external events [28] are also hypothesised to be relevant to the exacerbation of OCD in childhood.

### *Psychological Treatments: The Role Of Family*

Consistent with previous considerations, family involvement in the treatment of children with OCD has been widely suggested [29-31]. In fact, children need significant family support in order to address OCD symptoms and parents need specific tools (e.g. behaviour modification strategies) to help their children to implement the treatment program at home [32]. Moreover, since high levels of hostility and criticism (expressed emotion) have been associated with child OCD symptom severity and greater family accommodation [21], involving parents in child OCD treatments is important for three reasons.

First, because hostility and criticism could result from parents' believe that children with OCD could control their compulsions [33] and that they tend to be manipulative with their obsessions and compulsions [34], a family intervention could be useful for parents to understand their children's problem. Thus, explaining the genesis of the behaviors, delineating the boundaries of the disorder and attributing mental health symptoms to the illness (external attribution) rather than to the patient (internal attribution) may help parents have a more positive attitude toward OCD symptoms [34] and to moderate high expressed emotion [35]. Second, including parents directly addresses parents' tendency to accommodate their child's OCD behaviour [36]. Third, training parents to be coaches for their children plays a key role in shaping treatment and ensures adherence and motivation outside of the treatment session [36].

Various forms of family therapy are used in the treatment of paediatric OCD. Most interventions adopt behavioural therapy, involving exposure to feared situations and the prevention of compulsive behaviour [37], cognitive therapy, in which intrusive thoughts are identified, understood and discussed [38-41], and a combination of behavioural and cognitive therapy [42-44].

Cognitive-behavioural family therapy for young people with OCD is based on the recognition that families are so involved in the young person's rituals that family relationships are disrupted. Consistent with several works, cognitive-behavioural family treatment involves the parents, the child and the therapist [45-46]. The focus of the treatment is to help the family understand how their involvement can maintain the disorder and then help them withdraw from the compulsions. Although the aim of cognitive-behavioural family therapy is to improve family relationships, the focus is more on reducing the affected individual's obsessive-compulsive symptoms [47].

Few treatment interventions have adopted systemic family therapy approaches for paediatric OCD cases. General systems theory assumes that living organisms can be seen as a group of elements in interaction with one another, forming stability over time, with boundaries within itself and between itself and the environment. The system has properties such as wholeness and non-summativity (the whole is greater than the sum of its parts), feedback incorporated to maintain the function of the system (homeostasis), and equifinality (the same endpoints can be reached by different stimuli (the organisation of the system is more significant in determining reactions) [48].

In OCD treatment, systemic family therapy tends to focus on the meaning of the symptoms within the family unit. In this approach, family treatment involves the parents, the OCD child, siblings and the therapist [49]. The therapist tends to see OCD symptoms as a sign that the family unit is stressed, leading to difficult, unspoken emotions between family members [47]. These interventions aim at altering the family system, improving relationships, and increasing communication and emotional expression amongst family members. While these family interventions have included procedures designed to alter family dynamics directly [50-51], they have often also included behavioural components [51-52]. Other interventions have adopted systemic family therapy approaches where OCD has been considered to represent a metaphor for family dysfunction [51-52].

#### *Techniques used in family therapy for OCD children*

Cognitive behavioural therapy is widely recognized as the first-line treatment for young people with

OCD [31, 53-55].

It has been suggested that involving family in cognitive behavioural therapy allows children to enter anxiety-provoking situations in a planned way and to manage these through the use of coping skills and parental support [56].

1) In cognitive-behavioural family therapy both parents and children attend separate group sessions and some concurrent family therapy sessions [57]. Cognitive-behavioural family therapy offered to individuals or groups has been found to be equally effective [31]. The main components of cognitive-behavioural family therapy are:

2) *Psychoeducation*. This typically includes discussion of the nature of the disorder, its causes, prevalence, prognosis, maintenance factors, and effective treatments for it. It is important "to externalise the problem", clarifying to both family and the person with the disorder that OCD is a medical illness which is distinct from the youngster's core identity [58]. Externalising OCD in this way helps the child and family to feel empowered and to decrease anxiety [59] and assists parents to reduce hostile attitudes toward their child. It has been found that relatives who believed that people with OCD could control their compulsions were likely to be more hostile and critical than those who considered the OCD symptoms to be an illness [33]. Psychoeducation also aims to clarify that both the child and family already have some influence over this disorder [58]. So the therapist, child, and family become members of the same team with a unified goal of helping the child eliminate OCD from his or her life [58].

3) *Parenting tools*. Parents are provided with a set of tools used throughout treatment to increase the child's motivation for change and to more effectively manage their child's OCD symptoms. The main parenting tools include differential attention, modeling, and scaffolding [60]. For differential attention the therapist explains to the parents that they can use their attention to change their child's behaviour. So, they can give attention to behaviour they want to see and withhold attention from the behaviour they do not want to see [32]. For the modeling, the therapist explains how parents can positively reinforce the child's behaviour by giving positive attention and tangible rewards [60]. For the scaffolding, the therapist explains how parents can guide their child's emotion regulation in response to

an event so that the child internalises his or her response through self-regulation [32].

3) *Exposure and response prevention*. This is directed at the young person with OCD and aims to get parents and children to actively work together. This treatment has been designed to expose the individual to provocative stimuli (e.g., touching a “contaminated” object) while simultaneously refraining from compulsions (e.g., hand washing) [29] and it has been found to be an effective treatment for children with OCD [4, 61]. In exposure and response prevention, firstly a hierarchy of symptoms is created. A hierarchy of rituals can be constructed which includes a rating for the degree of anxiety experienced by the youth when he or she refrains from carrying them out. The gradual nature of this approach allows the child or adolescent to increase his or her anxiety management skills [62].

4) *Homework*. This is given to the person with OCD at each treatment session. Tasks to perform at home relate to one or more of the items on the hierarchy, and usually begin with the lowest rated item. The purpose of this homework is for the child with OCD to practise mastery over the symptoms. The therapist must explain these homework assignments carefully to the child, emphasizing the importance of mastery over OCD each and every day [63]. In family therapy parents are asked to tolerate their own distress while they assist their children during upsetting exposure exercises and homework tasks [36]. Parents are also asked to monitor their child’s behaviour and to encourage self-exposure in a noncritical manner [64]. For example, if a child washes his or her hands several times per day, reducing the number of handwashings per day could be part of a homework assignment. Parents must then support the child in postponing his or her handwashing and at the same time, they must increase the length of the compulsion-free intervals [63].

5) *Anxiety management training*. For children with predominantly internalising symptoms, treatment often includes anxiety management training. This therapeutic “tool”, which includes progressive muscle relaxation, diaphragmatic breathing, and coping imagery [65], allows the child to better manage the changes in affect that occur before, during, and after exposure and response prevention [66]. In family intervention, anxiety management training involves teaching parenting skills for managing child distress and avoidance, parenting

skills for parents to manage their own anxiety, and parental communication and problem-solving skills [67].

While engaging family members in OCD treatment for young people has been broadly suggested as being important, only a few interventions pay particular attention to family accommodation [68-69]. In these interventions, antagonistic or accommodating behaviours were firstly identified and discussed. Then, if a family member was assessed as being too accommodating, that individual received homework assignments related to reducing the accommodation, such as working with the young person to come up with a plan to begin disengaging from help during a compulsion. In the case of an antagonizing family member, he or she received training in methods to disengage from the conflict [68-69].

Several studies have been conducted to evaluate the efficacy of cognitive-behavioural family therapy. These investigations have revealed that family therapy significantly decreases symptom severity, as well as symptom-related distress and impairment, and treatment gains have been maintained over time [31, 44, 53, 69]. However, despite its effectiveness, treatment response is less than perfect, with a substantial percentage (more than fifty per cent) of treatment recipients remaining symptomatic post-treatment [30].

### Predictors Of Ocd Treatment Outcome

In order to improve treatments for children with OCD, several studies have tried to identify predictors of treatment response in paediatric OCD or, in contrast, predictors of non response to treatment [70-71]. Recently, two interesting literature reviews focused on predictors of treatment response in young people with OCD [70-71]. Results suggested that parental high expressed emotion, hostile criticism, and emotional over-involvement [72-73] are associated with greater dropout and/or poor cognitive behavioural treatment outcome for people with OCD.

With regard to expressed emotion, it has been suggested that parents’ criticism does not appear to be problematic if it is not hostile. In fact, while criticism of OCD behaviours may serve as a motivator for people to seek therapy and work on their problem during treatment, hostile criticism appears to make it difficult for them to continue in treatment and to benefit from it [74].

Other studies have reported that high family accommodation was associated with a worse response to behavioural therapy in children with OCD [68, 74]. In addition, decreases in family accommodation during treatment predicted treatment outcome: helping family members disengage from compulsions and resist accommodation during behavioural therapy appeared to improve OCD treatment outcomes [68-69].

It has also been highlighted that greater obsessive compulsive symptom severity [70-71] and a comorbid diagnosis of a personality disorder [71] consistently predict poorer treatment responses for these individuals.

Finally it has been displayed that the therapeutic alliance is a reliable predictors of treatment response: both child-therapist and parent-therapist therapeutic alliance, indeed, have been indicated as significant predictor of subsequent change in OCD symptoms treatment outcome [75].

## Conclusions

The studies on OCD in young patients in the present review indicate the reinforcing role of both expressed emotion [18, 74], that is a parental attitude characterised by hostility and criticism [22], and family involvement in the individual's rituals, either in an accommodating or antagonizing manner [10, 11, 14].

Given the central role of family in the development and maintenance of OCD in children and adolescents, including family members in the young person's therapy may be advantageous in order to educate and advise parents about OCD symptoms and how to respond to their child [29- 31]. Moreover, training parents to be coaches for their children plays a key role in shaping treatment and ensures children's adherence to treatment and motivation outside of the treatment session [36].

Several family-based treatments have been proposed for children with OCD. Most of these interventions have adopted cognitive-behavioural family therapy [42-43] while a few of these have used systemic family therapy [50-51].

Although most studies on OCD treatments emphasise improvements in young people's symptoms [31, 53, 69], some of them point out methodological flaws in these interventions and these reveal that treatment efficacy is less than perfect with more than an half of

children remaining symptomatic post-intervention [30].

All these concerns suggest to redefine our methodological approach to family therapy identifying the best method to achieve the greatest efficacy. The first issue concern therapy orientation. As previous mentioned, cognitive behavioural therapy, as the first-line of treatment for OCD paediatric patients, it is well structured and wide adopted. However, although the focus of the treatment is to the family, it usually involves the parents, the child and the therapist but not siblings [45-46]. On the other hand systemic therapy involves parents, paediatric patient, siblings and the therapist [49] but it has been less used in OCD treatment. Thus, it could be useful adopt cognitive behavioural family therapy as the first line of treatment but including siblings as suggested by Barrett [31].

The second issue concerns family factors that should be taken into consideration and managed in planning a family intervention for children with OCD. In this context studies on predictors of treatment response in young people with OCD are crucial [70-71].

Parental high expressed emotion, hostile criticism, and emotional overinvolvement [72-73] should be considered as predictors of treatment dropout. For this reason Steketee and colleagues [22] have suggested assessment and intervention strategies for reducing criticism and hostility during psychological treatment. Thornicroft, Colson and Marks [64] reported a treatment program where relatives were asked to monitor their child's behaviour and to encourage his or her self-exposure in a noncritical environment. In this context, "externalising the problem" during the psychoeducational treatment component helps parents to become less hostile and critical toward the young person with OCD [33].

Another relevant family factor to take into consideration is family accommodation [68, 74]. As was previously mentioned, some strategies could be useful for managing family accommodation in family-based interventions for OCD young cases. Some of these are specifically focused on family accommodation [68-69], others have been designed to alter family dynamics [50-51], while others, moving from family-based treatment, can help parents to avoid inadvertent reinforcement of children's compulsive rituals [56].

Lastly the timing of the treatment seems to be another crucial variable. The findings from previous studies have indicated that symptom severity and the presence of a comorbid personality disorder should be taken into consideration in planning OCD treatment [70-71]. These data emphasize the importance of treating OCD as soon as possible. In fact, if left untreated, or if inadequately treated, there is an increased likelihood that the OCD in these young children will extend into their adulthood [60], thereby enhancing the severity of their obsessive compulsive symptoms [76]. Moreover, leaving OCD untreated increases the risk of comorbidity in adulthood [77].

However, as Maskey [34] noted, despite the considerable distress and disability accompanying OCD, most parents do not recognize the nature of the disorder. As such, it is often unrecognised and undertreated. Family members need to be able to recognise various presentations of OCD. To assist with this, health promotion activities focused on OCD could be carried out both in schools and at the public health service. In this way family members could be informed about OCD and refer their children and adolescents to a specialist without delay.

Finally, in order to improve OCD interventions for youth, more studies on predictors of OCD treatment response are crucial since these can suggest factors that should be taken into consideration in planning interventions for children with OCD.

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## Author Introduction



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